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AUTHOR Rippens, Paula D.; Baldwin, Cynthia
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ABSTRACT

One dynamic that is often neglected in treatment of child sexual abuse is that of how a child's premature indoctrination into sexualized behavior, and the behaviors themselves, may inadvertently contribute to the overall victimization process. Children are capable of experiencing physical and psychological pleasure from sexual stimulation and are entitled to safeguards and freedoms from which to explore these developmental behaviors. However, they can also be vulnerable to inappropriate manipulations and attentions. Children can recognize the various benefits and rewards from compliant sexual participation. They may even initiate sexual behaviors such as flirtation, which have been modeled or reinforced. Therefore, it is highly possible that sexually abused children have been inappropriately and prematurely indoctrinated to respond to their environments and significant others in a developmentally sexualized manner. If children are not injured or frightened, they may engage in a progression of sexualized behaviors and may even manipulate sexualized activities for perceived gain. The perpetrator may see this as evidence that the child is sexually provocative and willing to participate. Many victims of sexual abuse blame themselves for the experience. Counselors need to help these victims understand normal sexual feelings and sexuality development in children and how such childhood responses were natural given their situations. They also need to know that while children may exhibit or engage in sexually provocative behaviors in an attempt to garner attention and/or affection, they are developmentally unprepared to associate such behaviors with true "consent' as defined by adults. Contains 19 references. (JE)

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Issues of Premature Indoctrination into Sexualized Behavior

Paula D. Rippens
Doctoral Candidate
Social Psychology

Cynthia Baldwin, Ph.D.
Associate Professor
Counseling and Educational Psychology
University of Nevada, Reno

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Abstract

There are many dynamics encompassed by the experience of child sexual abuse which must be assessed and addressed by counselors. One dynamic that is often neglected in treatment is that of the child's premature indoctrination into sexualized behavior and how it may contribute to the victimization process. The focus of this paper is to examine child sexuality and the potential impact this dynamic may have on the abuse victim, her/his family and associates, and ourselves as treatment planners.

The current decade has seen increased attention to the seriousness of childhood sexual abuse in scholarly research and media coverage (Olafson, Corwin, & Summit, 1993). In 1979, Finkelhor published an empirical survey of New England college students which cited 19% of the women and 9% of the men reporting experiences of child sexual abuse (CSA), touching off controversy about the prevalence of such experiences. In 1983, Russell conducted a survey of randomly selected women in San Francisco where 38% of the subjects reported being sexually abused as children. In 1985, a comparative statistical study of Afro-American and White American women done by Wyatt and the 1985 Los Angeles Times national survey (Crewdson, 1988), both found child sexual abuse reported by 27% of the women and 16% of the men surveyed (Beitchman, Zucker, Hood, DaCosta, Akman, & Cassavia, 1992; Finkelhor, Hotaling, Lewis, & Smith, 1990). While the percentage of those reporting child sexual abuse varies, even the conservative methodological estimates concur that 15-20% of women and 3-8% of men report CSA experiences (LoPiccolo, 1992).

The effects of child sexual abuse have been reported by clinical and counseling professionals as nearly always a profoundly disruptive, disorienting, and destructive experience for the child (Sgroi, Blick, & Porter, 1981). Research examining the initial or short-term effects of CSA on children has indicated that many of these children display poor self-image, sleeping and eating difficulties, bad dreams, oversexualized behaviors, irrational fears, and general "acting out" behaviors

(Beitchman et al., 1992; Browne & Finkelhor, 1986; Friedrich, 1993). Studies investigating the long-term effects of CSA in adult survivors have found significant correlations between CSA and various symptoms of serious inter- and intrapersonal dysfunction. Correlations exist with symptoms of depression, eating and sleeping disorders, sexual problems, shame and guilt, low self-esteem, fear, anxiety, and suicidal ideation in adults with CSA histories (Beitchman et al., 1992; Finkelhor et al., 1990; Summit, 1983; Summit & Kryso, 1978). Consequently, the effects of child sexual abuse are often found to be devastating initially to the child victim and, in many cases, detrimental in the long-term to the psychological well-being of the surviving adult. Thus, CSA and its effects are a problem of social and moral significance that must be faced by society and the health care professionals who treat and counsel affected individuals.

There are many dynamics encompassed by the experience of cild sexual abuse which must be assessed and addressed by marriage and family counselors and other mental health professionals. One dynamic that is often neglected in treatment is that of how a child's premature indoctrination into sexualized behavior, as well as the behaviors themselves, may have inadvertently contributed to the overall victimization process. The focus of this paper is to examine the role that prematurely sexualized behavior may have played in fostering the abuse and distorting the self-perceptions and development of interpersonal skills in the child.

Healthy Sexuality and Children

Children are already physically capable of experiencing sexual stimulation and feeling the pleasure it can arouse at birth. Developmentally, sexual feelings and exploration are an integral part of the process of human maturation (Finkelhor, 1984; Gray, 1987; Tharinger, 1990). Infants tend to explore their own bodies and rather quickly discover their genitals. Toddlers frequently self-stimulate/masturbate freely and openly unless restricted by caretakers. Usually by the age of three years, children have recognized differences between males and females and become curious about their sex and genitalia (Serbin & Sprafkin, 1987). Slightly older children often mimic, with disconcerting accuracy, observed behavior which has sexual overtones, especially posturing and touching. These behaviors are age-appropriate and an integral part of sexuality development. Thus, children are entitled to a blend of safeguards and freedom from which to explore these developmental behaviors. Healthy sexual attitudes and feelings are generally considered to be a result of healthy, appropriate sexual socialization by parents, family members, peers, schooling, and media (Calderone, 1983; Tharinger, 1990).

Sexual Vulnerability to Manipulation

Since children are capable of experiencing both physical and psychological pleasure from sexual stimulation, they become vulnerable to the inappropriate manipulations and attentions of a perpetrator. This is especially true if the perpetrator is

perceived by the child as being particularly important to her/his well-being, such as a father, mother, step-parent, grandparent, or older sibling (Beitchman et al., 1992; Browne & Finkelhor, 1986; Russell, 1986). Children are also capable of recognizing various benefits (specialized attention, affection, or avoidance of punishment) or rewards (material gain) which can be attained through compliant sexual participation. Children may even initiate sexual behaviors such as flirtation, which have been modeled or reinforced. Bandura (1986) refers to this behavioral phenomenon as "control through indoctrination," and contends that once such indoctrination becomes fully adopted, an individual will strongly adhere to learned behaviors even under diverse conditions. Therefore, it is highly possible that sexually abused children have been inappropriately and prematurely indoctrinated to respond to their environments and significant others in a developmentally sexualized manner that may become behaviorally integrated and persist over time.

Consequently, if the child is not injured or frightened by the sexual attentions of the perpetrator, she/he may willingly engage in a progression of sexual behaviors over time. In fact, the reinforcing benefits of the sexual relationship, even if personally discomforting for the child at some level, may motivate her/him to initiate or even manipulate sexualized activities for some perceived gain (immediate or anticipated). This inappropriately sexualized behavior becomes part of a range of behaviors for such children under the deviant modeling

conditions of their childhood environment.

Unfortunately, these children's sexualized behaviors tend to be viewed by potential abusers as unequivocal evidence that the child is sexually provocative and willing to participate in sexual activities. From this perspective, the perpetrator may be portrayed as not fully responsible and the "abuse" discounted or considered not to have occurred because of the presumed willingness or compliance of the child. Hence, the child who was inappropriately indoctrinated to sexualized behavior may be seen as a willing participant and therefore, held responsible, either in part or whole, for the sexual relationship. However, it must be understood by marriage and family counselors and other mental health professionals dealing with child sexual abuse that children lack the emotional, maturational, and cognitive development necessary to comprehensively assimilate or withstand premature indoctrination into mature sexuality by an adult and are therefore, not responsible for the role that their sexualized behaviors may play in the sexual abuse (Sgroi et al., 1981).

The Need for Intervention

Individuals who have endured the disruption of normal childhood sexual development and have had to cope with sophisticated sexual advances and abuse might be sexually confused, mistrusting, and atypical from the onset of such advances through to adulthood. Such confusion in perception, thoughts, and feelings have led many CSA victims and survivors to develop distorted beliefs and attribute blame for the abuse to

themselves. The shame and guilt often experienced by these afflicted individuals may be a direct result of having initiated certain sexual or flirtatious activities, complied in the sexual abuse, or felt some form of pleasure during its occurrence.

In order to help clients work through these distorted thoughts or feelings about themselves and their sexualized behavior, marriage and family counselors and other mental health professionals need to address the normal psychological and biological responses children will naturally develop in the sexual abuse environment. These children do not understand what is happening, may be disturbed by the situation, uncomfortable with their own feelings, and confused by the seductive assertions and behaviors of the perpetrator. They inevitably cultivate the only coping strategies available to their immature level of development (those modeled or taught) and suffer the deviantization and stigmatization such strategies often result in.

Therefore, it is crucial for individuals who were abused sexually as children and their partners to understand normal sexual feelings and sexuality development in children and how such childhood responses were natural given their situations. They also need to know that while children may exhibit or engage in sexually provocative behaviors in an attempt to garner attention and/or affection, they are developmentally unprepared to associate such behaviors with true "consent" as defined by adults. Once again, it is critical to emphasize to the abused

individual and her/his partner that children lack the emotional, maturational, and cognitive development need to comprehend the implications and ramifications of a mature sexual relationship.

Conclusion

Interventions for survivors of sexual abuse need to take a stronger aim at addressing cognitively distorted attribution processes and misinformation regarding childhood sexuality with clients as well as their partners, their families and society in general. Addressing these sexuality issues in children may allow the sexual abuse survivor and her/his partner to properly assign responsibility for the premature initiation into sexual relations to the perpetrator and better understand the role of their own feelings and behaviors in the victimization process.

Furthermore, assisting the CSA victim/survivor to comprehend and embrace the spontaneous character of her/his natural biology (from infancy to adulthood) can potentially foster acceptance of experiences previously held to be shamefully unique. The curiosity and physiological pleasure aroused by sexual stimulation are natural and normal at any age. What to do about those sensations is something learned through developmental progression and needs to be responsibly guided by caring and informed socializing agents (e.g. parents, family, school, counselors). This is also true of the psychological aspects of needing and wanting attention and affection; any child will "rightfully" pursue these needs with whatever behavioral tactics

are available. It is up to those caring for the child to teach her/him suitable ways of indicating such needs and then, appropriately providing for them.

Thus, counselors must normalize this critical dynamic of distorted self-perceptions and internalized guilty or shameful secrets about sexualized behavior in their treatment of CSA clients while compassionately educating and encouraging them and their families to recognize their "faulty" attributions of blame and responsibility. If this frequently suppressed and ignored effect of CSA can be brought out into the light, treatment may start to show more effective and timely outcomes.

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